Kindred Healthcare

RehabCare

PeopleFirst Homecare and Hospice

AP Expense Report (Only) Direct Deposit Agreement Form

Please indicate if this is a new request or change:

New ■ Change

Authorization Agreement

I hereby authorize Kindred Healthcare, Inc. to initiate automatic deposits to my account at the financial institution named below. I also authorize Kindred Healthcare, Inc. to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold Kindred Healthcare, Inc. responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until Kindred Healthcare, Inc. receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the Accounts Payable Department.

Employees have two options to choose from (choose one):

☐ **Option 1:** Check this option if you elect to use your primary bank account from your payroll direct deposit.

☐ **Option 2:** All employees who elect to deposit in an account other than their primary payroll depository account must fill out all the information below and **submit it with a copy of a voided check .**

Provide the following if you elect to use another account other than your primary payroll for Direct Deposit.

- **Routing Number:** _____ **Checking** ☐ **Savings** ☐
- **Account Number:** _____

If you have any questions, please contact Aptravelcorp@kindredhealthcare.com

The Following Information Is Required for Either Option

(this section must be completed and legible or your request cannot be processed)

Authorized Signature: _____ Date: _____

Print Full Name & Title: _____

Email Address: _____

Home Address: _____ City/State/Zip: _____

Kindred Personnel #:_____ Cost Center #: _____

(This is located top/center of your Kindred payroll check stub) *(This is located under the personnel number)*

Please mail this form to
Kindred Healthcare, Inc.
c/o AP Travel & Expense
680 South 4th Street
Louisville, KY 40202
Or Fax to: 502-596-7306
Or Email to: Aptravelcorp@Kindredhealthcare.com

For Accounting Use Only

SAP Vendor #_____ In Concur ☐ Concur ☐ SAP ☐

Cost Center / Company Code: _____ Live Check/SAP ☐

PerNumber: _____ Payroll DD ☐ Payroll Live Check ☐

OIG/GSA Completed if required: ☐